THE ATTORNEY GENERAL'S

1998 REPORT ON

HOSPITAL COMMUNITY BENEFITS

JANUARY 1999

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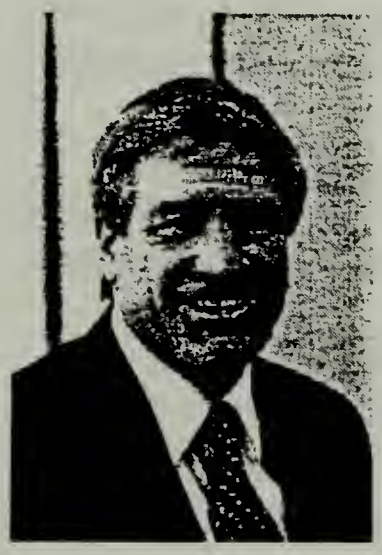
January 1999

Dear Friends and Colleagues:



I am pleased to issue the second Status Report on the implementation of the Community Benefits Guidelines for Nonprofit Acute Care Hospitals in Massachusetts. This Status Report is the result of a careful review of the Annual Community Benefits Reports filed with my office by every acute care hospital in the Commonwealth for fiscal years 1996 and 1997.

This Report reflects the remarkable growth and maturity of Community Benefits Programs across the Commonwealth over this two year period. Since my office issued the Guidelines in 1994, hospitals have developed a multitude of innovative community-based programs to address the health care needs of underserved and vulnerable populations. They have worked hard to implement the Guidelines' core principles by developing Community Benefits Plans based upon needs assessments and partnerships with the community and its stakeholders. They have and hopefully will continue to take Community Benefits to new and better levels.

The hospitals and their collaborators should be recognized for the significant contributions they have made to improving the health status of their communities. The hospitals provided $106.7 million in FY 1996 and $124.2 million in FY 1997 in Community Benefits and community service efforts. When unreimbursed free care shortfalls are added, the total rises to $305.7 million in FY 1996 and $290 million in FY 1997.

Of course, the numbers alone do not and cannot present the full picture of how Community Benefits have made a difference in the lives of Massachusetts citizens across the Commonwealth. This impact goes beyond the provision of services, as hospitals and their community partners develop collaborative and comprehensive approaches toward working for healthier and more sustainable communities.

The Community Benefits Initiative is a program of which we should all be proud. Thank you for your interest and participation in this ground breaking effort.

Sincerely,

Scott Harshbarger

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THE ATTORNEY GENERAL'S 1998 REPORT ON HOSPITAL COMMUNITY BENEFITS

EXECUTIVE SUMMARY

In 1994, Attorney General Scott Harshbarger became the first Attorney General to issue voluntary Community Benefits Guidelines for Nonprofit Acute Care Hospitals ("Guidelines"). These Guidelines encourage hospitals to institutionalize their commitment to Community Benefits, establish formal Programs, and engage in a planning process to identify the community's health needs, set priorities, and develop an integrated Community Benefits Plan. The Guidelines also emphasize the importance of extensive community involvement at every step of this process.

In 1997, the Attorney General issued his first Status Report on the implementation of the hospital Guidelines. This is the Attorney General's second Status Report and reviews the hospitals' Annual Community Benefits Reports submitted to his office for fiscal years 1996 and 1997.

During this two year period, every acute care hospital or hospital system in Massachusetts filed at least one Annual Report documenting its participation in the Community Benefits effort, and nearly 90% filed two reports. These Reports reflect the positive development in hospital Community Benefits Programs across the Commonwealth.

Some of the highlights from the Attorney General's review and analysis of the hospitals' Annual Reports are as follows:

- Hospitals provided a total of $106.7 million in FY 1996 and $124.2 million in FY 1997 in Community Benefits and community service efforts. When unreimbursed free care is added, the total rises to $305.7 million in FY 1996 and $290 million in FY 1997.

- Hospitals reported on over 1500 Community Benefits Programs or community service efforts for their fiscal years 1996 and 1997. A categorization of these efforts (as self-reported by the hospitals) reveals the following:

  * Approximately 25% of Community Benefits or community service efforts are devoted to community education;

  * Over 14% of the efforts provide community development assistance, such as improving job opportunities, environment and housing;

  * About 13% of the efforts improve access to care through subsidies, transportation, information lines, and interpreter services;

  * 12% of the efforts provide direct care to the community;

  * 11% of the efforts consist of screenings for health problems; and

  * Over 10% of the efforts focus on prevention of family abuse, community violence, and/or

substance abuse.

Additional information on this categorization is included in Appendix C.

- Community Benefits Programs have matured significantly. More hospitals have engaged in a formal planning processes by developing Community Benefits Plans that result from needs assessment, prioritization, and community participation. There has been a positive movement from providing unrelated community services to establishing comprehensive Community Benefits Programs.

- Most hospitals have institutionalized Community Benefits by adopting a Board-approved Mission Statement and establishing an internal Community Benefits structure. Many hospitals now have a full or part time staff position dedicated to Community Benefits. Board involvement and budgetary approval are less consistent.

- The number of hospitals with some form of community participation has improved dramatically. Over 65% of hospitals in FY 1996 and 82% of hospitals in FY 1997 reported having a formal channel of community input. Hospitals also reported a number of different methods used to obtain community involvement, including advisory groups, participation in already-existing coalitions, and conducting public hearings.

- Approximately 88% of hospitals have completed or are in the midst of conducting a needs assessment. There was a fair amount of variation in the quality of these assessments.

- Several hospitals participate in community-wide collaborations that have generated impressive results.

- While more hospitals provided financial information in their Annual Reports (85% in FY 1996 and 89% in FY 1997), financial reporting continues not to be uniform. Some hospitals combined Community Benefits and community service budgets, included unexplained items in their Budgets, or did not provide gross and net figures. There was also inconsistency in the reporting of unreimbursed free care figures. Working in consultation with the Massachusetts Hospital Association ("MHA"), the Attorney General's Office has developed a uniform financial reporting template in hopes of averting such problems in the future. A sample of the template is included at Appendix D.

In sum, the Annual Reports show that hospitals have made substantial achievements in their Community Benefits Programs to varying degrees. Many hospitals continue to make strides and are taking Community Benefits to the next level. Other hospitals have not advanced as quickly. The overall picture, however, is very heartening and positive.

Community Benefits have made a significant contribution toward improving the health of individuals across the Commonwealth. This statewide, co-operative effort has created new partnerships and collaborations, and encouraged innovative ways of thinking to address health care issues. As Massachusetts moves into the 21st Century, we hope that hospital Community Benefits Programs continue to expand, evolve, and improve the health status of all of our communities.

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INTRODUCTION

In June 1994, Attorney General Scott Harshbarger became the first Attorney General in the nation to issue voluntary Community Benefits Guidelines for Nonprofit Acute Care Hospitals. Now in its fourth year of implementation, hospitals across the Commonwealth, in collaboration with their communities and other service providers, have established or strengthened their commitment to making community benefits an integral part of their institutional missions.

This Report reflects the status of the Massachusetts Community Benefits Initiative for hospitals for their fiscal years 1996 and 1997. This is the second Status Report prepared by the Attorney General on the hospitals' community benefits experience in Massachusetts. This Report is based upon review and analysis of the Annual Reports submitted by the hospitals pursuant to the Guidelines for each of the two years during this period.

For this period, there was 100 percent hospital participation in the Community Benefits Initiative. Every acute care nonprofit hospital or hospital system filed at least one Annual Report, and nearly 90 percent filed two Annual Reports.[1] These Reports indicate that Community Benefits Programs across Massachusetts continue to evolve and expand at a healthy rate.

At present in Massachusetts, there are still hundreds of thousands of people who lack adequate or affordable insurance, and therefore the importance of Community Benefits remains vital.

RECENT DEVELOPMENTS IN THE ATTORNEY GENERAL'S COMMUNITY BENEFITS INITIATIVE

1. ISSUANCE OF THE ATTORNEY GENERAL'S STATUS REPORT ON HMO COMMUNITY BENEFITS

In 1996, Attorney General Scott Harshbarger became the first and only public official in the nation to issue voluntary Community Benefits Guidelines for Health Maintenance Organizations. In February 1998, the Attorney General's Office issued the first-ever Status Report on HMO Community Benefits Programs. The Status Report reviewed and analyzed the first round of HMO Annual Reports, for which there was also 100 percent participation by HMOs in Massachusetts.

2. FINANCIAL REPORTING TEMPLATE AND SUMMARY GUIDANCE SHEET.

In May 1998, the Attorney General's Office made two additional reporting aids available to all hospitals participating in the Community Benefits initiative: (1) an updated list of recommended components for the annual filing; and (2) a template for the reporting of the Community Benefits budget.

Working in consultation with MHA, the Attorney General's Office developed the guidance sheet and financial reporting template in the hope that they would help remedy a number of reporting problems:

a. Some hospitals were still filing lists of programs without the context of a full Community Benefits process. The guidance sheet therefore refocused attention on the key steps involved in developing a methodical Plan. Since one overriding goal of the Attorney General's initiative is the marriage of program to need, hospitals were asked to describe with greater particularity the procedure used to determine those needs.

b. In a number of cases, the person assigned to draft the Annual Report was new to the position and had not participated in any formal training session. In order to avoid repeated and lengthy individual explanation, the Office issued a second guidance checklist.

c. Particular steps in the planning process, such as the Community Benefits inventory, needed clarification.

d. Uncertainty as to the difference between Community Benefits and community service programs, as to what should be counted as a Community Benefit, and as to what constitutes net charity care called for additional explanation. The financial reporting template provides specific definitions of these terms. A copy of the financial reporting template is at Appendix D.

e. The sketchy nature of financial information disclosed in many hospital reports.

3. TRAININGS

Accompanying the two reporting aides were a series of trainings. The first, on May 27,1998, was hosted by MHA and included formal presentations from two Community Benefits coordinators, questions from teleconferenced audiences, and comment from Attorney General staff. Financial reporting was the focal issue. Opinions differed as to what to count and how. Some of these questions involved characterization of "bad debt" or payments into the uncompensated care pool or Medicaid shortfalls.

Two informal roundtables were held at the Office of the Attorney General in June 1998. Borrowing from the MHA's concept of networking sessions, the roundtables were an opportunity

for community benefit coordinators to learn from each other. The two hour sessions also provided an opportunity for the Attorney General's staff to learn about the variety of internal institutional arrangements that facilitate or hinder the development of innovative programs.

Future training sessions might be in the form of mentoring tutorials attended by other hospital community benefits coordinators, community representatives, and staff from the Massachusetts Department of Public Health and the Division of Health Care Finance and Policy. These tutorials could provide technical guidance on particular aspects of the process of assessing needs, establishing priorities, and integrating evaluative mechanisms.

4. Community Benefits Advisory Task Force

In June 1998, Attorney General Scott Harshbarger formed a Community Benefits Advisory Task Force for the purposes of furthering the development of the Community Benefits Initiative in Massachusetts. The Advisory Task Force is composed of representative hospitals and HMOs, community health care advocates, trade associations, community health centers, academics, and officials from state and local government agencies. The Task Force has been divided into five working groups which focus on the following areas: Community Participation, Needs Assessment and Outcomes Evaluation, Implementation Issues, Conference Planning, and a Collaborative Public Health Initiative.

On October 29, 1998, the Attorney General and the Advisory Task Force held the first-ever statewide Conference on Community Benefits. This Conference featured case studies on specific Community Benefits Programs; panels on Needs Assessment, Outcomes Measurement, and Building Institutional Support; and small group Roundtable Discussions on Community Participation. The Attorney General's Office will be issuing a report on this Conference, which will be available upon request from the Public Protection Bureau.

THE ANNUAL REPORTS

The following section analyzes the Annual Reports filed by the hospitals for their fiscal years 1996 and 1997. For this period, we are pleased to report that all 65 acute care hospitals and hospital systems in Massachusetts filed at least one Community Benefits Annual Report,[2] and the overwhelming majority (57 or 88%) filed two Annual Reports. For the remaining few hospitals, most filed only one Annual Report because of fiscal year issues or changes.

A. The governing body of each hospital should affirm and make public a Community Benefits Mission Statement, setting forth its commitment to a formal Community Benefits Plan.

As noted in the first Attorney General's Status Report, there was substantial fulfillment of the basic elements of this Guideline. All but six hospitals have adopted a special Community

Benefits Mission Statement. Most of these hospitals (48 out of 59 or 81%) have also reported that their Boards of Directors have approved the Mission Statement, thus indicating a firm institutional commitment on the part of these hospitals.[3]

In almost all of the Mission Statements (53 out of 59, or 90%), hospitals acknowledged the importance of collaborating or partnering with their communities, or with other social service and health care providers. Slightly under two thirds of the Mission Statements commit their hospitals to implementing a formal Community Benefits Program. In about half of the Statements, hospitals pledged to allocate resources toward their Community Benefits Programs.

The diversity of the Mission Statements is striking and reflects the multitude of different approaches that the hospitals took toward expressing their commitment to Community Benefits. The Mission Statements vary in length from one paragraph to several pages. Many of the Statements speak in powerful and moving ways of the needs and plight of underserved and uninsured citizens of this state. Other hospitals make specific commitments in their Mission Statements, pledging to address certain health care priorities. Some of the hospitals also committed in their Mission Statements to fulfilling certain elements of the Community Benefits planning process, such as a needs assessment and setting priorities. A few hospitals issued their Mission Statement in an unusual manner, by including it in the hospital's overall Mission or using the Mission Statement of a pre-existing Community Relations Office.

B. The Governing Board and senior management should be responsible for overseeing the development and implementation of the Community Benefits Plan, the method to be followed, the resources to be allocated, and the mechanisms for the regular evaluation.

This Guideline contains two major concepts regarding the implementation and oversight of the Community Benefits Programs: (1) that each hospital establish an institutional structure to carry out these tasks; and (2) that the highest levels of each hospital's leadership be actively involved in overseeing its Community Benefits Community Benefits Program.

1. Institutional Structure

Almost every hospital fulfilled the first component, i.e., establishing an institutional structure for their Community Benefits Programs. Sixty-three hospitals, or over 97%, have a staff member or group who has responsibility for coordinating the Community Benefits Program for the institution.

There is a striking diversity in the ways in which hospitals established their institutional structures. Some hospitals have created committees or advisory councils to oversee Community Benefits, which might be composed of staff, senior management, Board members, and/or community members. Other hospitals have hired one or more staff person(s) to manage Community Benefits. The growth in the number of hospitals which have a full or part time Community Benefits Coordinator is very encouraging. In contrast to this positive development, a few hospitals still continue to delegate Community Benefits to departments which are not optimally suited for the task.

Some Annual Reports have exceeded the Guideline's expectations by not only describing their institutional structures, but by providing detailed explanations of the individual roles and duties of their Community Benefits staff, staff/Board committees, or Advisory Councils. A few hospitals even included flow charts of how these roles and duties fit into the Community Benefits planning process. These reports serve as examples of how hospitals might benefit by establishing clear expectations for the individuals who carry out their Community Benefits Program.

2. Board Involvement

The Annual Reports indicated less consistency with respect to the second component of this Guideline, i.e., involvement by the hospital's Board of Directors. A significant number (26 or 40%) of the Reports did not indicate whether their Board had reviewed and approved their Community Benefit Plans, and even more Reports (47 or 72%) did not discuss the budgetary approval process for Community Benefits. A few commendable Reports did indicate that they had integrated the Community Benefits budget into the overall hospital budget.

Involvement by the highest levels of the organization is critical for a Community Benefits Program to receive acceptance on an institutional level. Without the support of the Board and senior management, a Community Benefits Program is less likely to be viewed as an integral part of a hospital's mission. For some hospitals, however, the apparent absence of high-level involvement may constitute more of a reporting issue than a substantive problem.

On a more positive note, several Annual Reports show a remarkable involvement by senior management or the Board. For example, several hospitals include the briefings about their Community Benefits Programs as a regular agenda item at Board meetings. Other hospitals have Board-level Community Benefits committees on which the Chair of the Board sits.[4]

C. **A hospital should delineate a specific community or communities that will be the focus of its Community Benefits Plan and should involve representatives of that designated community in the planning and implementation process.**

1. Delineating the Community

With respect to the selection of target populations, we did not observe much change from the first Attorney General's Status Report. As would be expected, almost all of the hospitals retained the same target population, most of which utilized a geographic definition of community.

2. Community Process and Input

Community participation is at the heart of Community Benefits. The Guidelines stress that hospitals should consider their communities as partners at every step of the planning process: delineating the community, conducting needs assessments, selecting priorities, and developing the Community Benefits Plan.

The Annual Reports show a remarkable improvement in this area over the last two years, as the number of hospitals having some form of community participation has increased dramatically. For fiscal year 1996, 43 hospitals or over 65%, report having a formal channel for community input. For the fiscal year 1997, this percentage increased to 82% (53 hospitals).

Even more impressive, the Annual Reports describe a myriad of different ways in which hospitals obtain community participation. Some hospitals have created Advisory Groups which included representation from various sectors of the community, such as grassroots organizations, social service providers, school personnel, law enforcement, religious institutions, businesses, and local municipal agencies. Other hospitals obtain community input by participating in already-formed community coalitions or the Department of Public Health's Community Health Network Areas (CHNAs). Some hospitals use a centralized channel of community input, while others have created decentralized structures in which community representatives participate on subcommittees focusing on individual projects, e.g., a Domestic Violence Subcommittee or a Cardiovascular Health Working Group. In a few cases, hospitals obtained input directly from community members through public hearings or "speak-outs."

This diversity of methods indicates that hospitals have met the challenge of obtaining community participation with innovation and flexibility, avoiding a "one size fits all" formula. We believe that such variety is highly beneficial, because hospitals are more likely to have meaningful community participation if they can choose a model that works best for them.

However, even though the overwhelming majority of hospitals do now have some mechanism for community input, it is inevitable that the level and quality of these mechanisms will vary. Some hospitals sought and obtained commendable levels of participation, going beyond mere consultation to true partnerships with their communities. Other hospitals appear to have only passive or token community participation, reflecting a hospital-driven process. Also, some Reports may have created the appearance of a weak community process because they did not provide enough information about it. For example, several Reports failed to identify the community representatives or organizations from whom they solicited input, information which the Guidelines specifically suggest should be included.

As a part of community participation, a hospital may want to publicize and distribute its Community Benefits Plan to its local community. Several hospitals have done so by creating colorful brochures or reports that are intended for public consumption. The best of these reports are reader-friendly without sacrificing important descriptions of the Community Benefits Program, especially regarding the planning process and budget. A few brochures, however, are no more than lists of activities and programs, creating the impression that a hospital has nothing more than a collection of community service activities developed without engaging in the recommended planning process. Quality substantive information about community benefits can be an important part of enhancing community participation.

D. A Community Benefits Plan should include a comprehensive assessment of the health care needs of the identified community as well as a statement of priorities consistent with the hospital's resources.

1. The Needs Assessment

The great majority of hospitals (57 or 88%) have completed, or are in the midst of conducting a needs assessment. Of the handful of hospitals that have not made an effort at needs assessment, several are specialty hospitals for which a needs assessment is less critical because they only provide health care services for certain medical conditions.

From our analysis of the reports, we noted that there was a fair amount of variation in the quality of needs assessments. Some hospitals conducted somewhat cursory needs assessments, only examining their internal hospital data and/or data from one other source. Other hospitals conducted sophisticated, in-depth needs assessments. Most of these assessments included community perception surveys, focus groups, or public forums.

There were some reports from which we could not discern the quality of the needs assessment because the report failed to describe it in any detail. In future years, it would be useful for the reporting on needs assessments to include information on the methodologies and data sources utilized, as well as a listing of all identified major needs.

For hospitals that had completed their needs assessment in previous years, many of them simply reiterated their results or referenced an earlier Annual Report. Using a needs assessment over a multi-year period is an efficient management of resources. In fact, the Guidelines suggest that hospitals should consider conducting needs assessments only once every three years.[5] However, it might be helpful for readers if hospitals provided the convenience of attaching a copy of a prior needs assessment or including a description in an Appendix.

Because needs assessments are resource intensive, the Guidelines encourage hospitals to use existing public health data available from organizations and agencies such as the Department of Public Health, the Division of Health Care Finance and Policy, the Massachusetts Prevention Centers, the CHNAs, the Department of Mental Health, and the Division of Medical Assistance. Most of the hospitals (50 or 77%) followed this suggestion.

Several hospitals went further, and saved valuable resources by conducting joint or collaborative needs assessments, or funding their CHNA to conduct an area-wide assessment. Other hospitals have worked with their local health department or other municipal or state agencies. Such collaboration is highly beneficial for all parties involved, and allows hospitals more time and resources to focus on other components of the Community Benefits planning process, such as obtaining community input, engaging in prioritization, and developing the actual Plan itself.

2. Establishing Priorities

By now, most of the hospitals (57 or 88%) have established a set of priorities for health care needs to be addressed by their Community Benefits Plans. In addition to setting forth the priorities, we found that the Annual Reports were most informative when they provided adequate details concerning the process of prioritization; otherwise, it was sometimes hard to understand the connection between the results of a needs assessment and the established priorities or the benefits actually provided. The number of hospitals with a "disconnect," however, appears to be decreas-

ing as more hospitals move away from simply providing community services and more toward establishing more formal Community Benefits Programs.

We should also note that the Guidelines do not encourage hospitals to prioritize simply based upon what a needs assessment finds is the most "pressing" health care need. Instead, the Guidelines suggest that a hospital consider a number of factors, such as the community's input, the income level of the affected population, barriers to access, absence of available resources, the hospital's own limitations and capabilities, and the capabilities of other service providers. The critical task is for hospitals to clearly articulate in their Annual Reports the reasons why they has established particular priorities.

3. Inventory and Collaboration

The Guidelines encourage hospitals to avoid duplication when developing their Community Benefits Programs. To do so, hospitals should: (1) inventory their own Community Benefits and community service projects and initiatives; (2) consider whether other existing programs might address the same needs prioritized by the hospital; and (3) actively coordinate or collaborate with other health care providers or social service agencies.

The majority of the hospitals followed this Guideline by conducting an inventory of their own Community Benefits and community service projects. More impressively, most of the hospitals (52 or 86%) also engaged in some form of coordination or collaboration with other health care or social service providers.

As for the second element, we observed that several hospitals had included an inventory of community health care assets in their needs assessments. Some of these hospitals engaged in "asset mapping," a technique which has been gaining popularity in both health care and general community improvement efforts.[6] We believe that asset mapping may be useful for hospitals seeking to improve or take their Community Benefits Programs to the next level.

Finally, the Guidelines encourage the development of community-wide planning and implementation of health improvement projects. Indeed, the Attorney General's Advisory Task Force is planning to engage in such broad collaboration by recommending a collaborative Public Health Initiative. In addition, a great many other collaborations have developed across the Commonwealth, such as the Healthy People 2000 Coalitions in several geographic areas. In some cases, hospitals have collaborated with each other and community partners to conduct joint needs assessments or to tackle specific health issues, such as asthma. Such community-wide, collaborative health planning may be one of the most valuable dividends from Community Benefits.

4. Underserved and Vulnerable Populations

The Guidelines call upon hospitals to give priority to the health care needs of underserved and disadvantaged populations. Many hospitals (52 or 80%) have heeded this call, providing community benefits that are targeted toward the underserved and/or improve access to health care. Several hospitals state a commitment to underserved or uninsured populations in their Community Benefits Mission Statements.

In addition, the Guidelines also urge hospitals to pay particular attention to the special needs of the poor, elderly, and racial/linguistic/ethnic minorities. The great majority of hospitals (61 or 94%) have done so. Some hospitals have created special programs for the young or elderly, while others ensure that their Community Benefits are provided in a linguistically and culturally relevant manner. In addition, 28 hospitals have established an interpreter services program. Some of these hospitals also have hired bilingual and bicultural outreach workers, and even translated their Annual Reports. Given the ever-increasing numbers of linguistic minorities in this state, efforts to overcome language and cultural barriers will become more of a necessary component for delivering competent health care to diverse populations.

E. The hospital should develop and implement its Plan in a timely fashion.

1. Initial Plan Development

After conducting a needs assessment and establishing priorities, in consultation with the community, the Guidelines call for hospitals to create an integrated, comprehensive Community Benefits Plan. Most hospitals satisfied this Guideline, as 48 hospitals, or 74% have developed some form of a Plan.

On a hospital-by-hospital basis, however, these Plans varied greatly in quality. Many hospitals have developed extremely thoughtful and sophisticated Plans. These Plans are the result of sophisticated needs assessments and are clearly aimed at addressing the hospital's target population and established priorities. They include short and long term goals and set forth time frames for implementation. In contrast, a few hospitals have Plans consisting of little more than a collection of activities and services, most of which appear to be more community service in nature.

Several hospitals have not yet developed a Community Benefits Plan, but indicated that they were making good progress toward creating one. Most of these hospitals have completed the needs assessment process, and they describe in their Annual Reports their plans to engage in the next steps of the planning process. Given that the Community Benefits Initiative is now in its fourth year of implementation, we encourage these hospitals to continue to move forward. These hospitals are on the right track, and have made significant progress toward creating intelligent and well-designed Plans.

2. Annual Review

In addition to developing a Community Benefits Plan, the Guidelines recommend that each hospital review its Plan and the corresponding results on an annual basis. In their annual review, hospitals should examine their Community Benefits Programs to ensure that the resources they expend continue to address a community need. In addition, hospitals should seek community input during these reviews.

Approximately half of the hospitals fulfilled this Guideline element by conducting an annual review. For the other half, many of these hospitals may not have conducted a review

because their Community Benefits Plans were only recently developed. The number of annual reviews should increase as the Plans mature and require updating.

F. Each hospital should submit an annual Community Benefits Report to the Attorney General's Office which discloses its level of community benefits expenditures and describes the hospital's approach to establishing those expenditures. The hospital should make the Report available to the public.

1. Financial Reporting

We are pleased to see that more hospitals have provided financial information over the last two years. For the FY 1996 Annual Reports, 55 hospitals, or 85%, submitted financial data in their reports. This figure improved for the FY 1997 Annual Reports, as 58 hospitals or 89% submitted financial information in their Annual Reports.

Again, the financial reporting varied in quality, with some hospital providing extremely detailed budgetary information, while others provided no more than lump sum figures. We are also pleased to report that, despite the fact that the financial reporting template was issued midway through the reporting cycle, 33 of the hospitals (over half) used it to report their Community Benefits Budgets for FY 1997.

Before giving a total figure, we should caution that there are several problems inherent in the budgetary reporting process. First, many of the less detailed budgets reported lump sum figures that included items which are questionable or are not consistent with the Guidelines definition of Community Benefits. Because they were reported as lump sum figures, these amounts could not be subtracted out. Second, a significant number of hospitals combined together Community Benefits and community service budgets. Again, we could not separate out these amounts, and therefore have reported these items together. We expect that this issue will not arise again next year because the financial reporting template clearly separates out these amounts. Finally, most hospitals continued not to provide gross and net figures for their Community Benefits budgets.

Bearing in mind the above caveats, we have calculated the total Community Benefits expenditures by Massachusetts acute care hospitals for their fiscal years 1996 and 1997. Relying on the information provided in the Annual Reports, we estimate that the 65 reporting hospitals provided a total of $106.7 million for FY 1996 and $124.2 million for FY 1997 in Community Benefits and community service programs.

We realize that the FY 1996 and FY 1997 total expenditures for Community Benefits and community service programs appear to be smaller than the total expenditure reported in the first Attorney General's Status Report. However, we believe that this phenomenon was not caused by an overall decrease in the hospitals' Community Benefits Budgets, but ironically may have resulted from better financial reporting.[7] In their first Annual Reports, many hospitals did not provide a separate figure for unreimbursed free care. Instead, they reported lump sum figures for their Community Benefits Budgets -- figures which may have included unreimbursed free care. As a result, the overall total expenditure for Community Benefits was inflated in the first Status Report,

while the overall unreimbursed free care total was under-reported.

As for the unreimbursed free care figures, the reporting on these amounts was uneven from hospital to hospital for various reasons. For example, some hospitals included their payments to the Massachusetts uncompensated care pool in their unreimbursed free care figures. Other hospitals may have calculated their unreimbursed free care on the basis of charges, even though the Guidelines encourage them to calculate the amount based upon actual costs. Some hospitals were unclear as to whether they were reporting gross or net charity care figures. Given these numerous issues, we decided to calculate unreimbursed free care expenditures using the uncompensated care pool shortfall figures from the Division of Health Care Finance and Policy. (The Massachusetts Hospital Association, however, believes the total amount of unreimbursed free care is much higher. Citing a 1996 study by the Department of Revenue and the Division of Health Care Finance and Policy, MHA estimates that Massachusetts hospitals provided an additional $80 million in unreimbursed free care to low-income, uninsured patients in FY 1996.)

When uncompensated care pool shortfall figures are considered, total Community Benefits and community services expenditures rises to more than $305.7 million in FY 1996 and $290.2 million in FY 1997. On an individualized basis, the great majority of the hospitals provided between 2 percent and 4 percent of their patient care-related expenses in Community Benefits and community services. A few hospitals provided a greater percentage. We caution against relying too heavily on these percentages because of the reporting issues discussed in this section.

The existence of confusion as to financial issues might be understandable for these prior fiscal years because of the lack of a uniform reporting format. With the development of the financial reporting template, we hope that the financial reporting for Community Benefits will be less problematic, more uniform, and easier to understand in future years. We recognize that financial reporting is often highly complex and difficult to complete. We should keep in mind that Community Benefits reporting, like the Programs themselves, is a work in progress that will continue to improve and evolve.

Finally, the amount of money spent is only one measure of a Community Benefits Program. Many benefits provided by a hospital are difficult to quantify, yet assist a community just as much as the quantifiable benefits. Many of these benefits relate to the hospital's sharing of its organizational capacity and resources. For example, several hospitals involved in larger community-based efforts provided the initiative and direction necessary to launch those efforts. Other hospitals spent resources to assist in community-based leadership development and local capacity building. While difficult to measure, we believe that the communities which benefit from these activities value them greatly.

2. Options for Measurable Objectives and Outcomes

In addition to submitting an Annual Report which discloses the level of community benefits expenditures, the Sixth Guideline also suggests methods hospitals could use to measure the short term and long term success of their Community Benefits Programs. These measures include: (1) counting the number of patients served for a particular project or effort; and (2) determining the improvement or reduction in a particular health status indicator.

We are pleased to note that over half of the hospitals included some evaluation component into at least one of the projects in their Community Benefits Programs. Twenty hospitals measured outcomes by counting number served, while 23 hospitals attempted to determine impact on health status. Other evaluation methods were less quantitative in nature. Most of the evaluation and outcome measures are relatively straightforward, which is to be expected given the relative youthfulness of the Community Benefits effort. Over time, it is likely that hospitals will be developing and using more complex outcome measurements as this entire area evolves and advances.

In developing these measurement tools, hospitals should also give the community a role in evaluating a Community Benefits Program. This will be especially critical for hospitals engaged in broad-based health improvement efforts.

Conclusion

Over the past four years, there has been much evolution and improvement in Community Benefits Programs across the Commonwealth. After much time spent in careful cultivation, many of these Programs are now coming into bloom. Together, these Programs are making a real difference in the lives of so many underserved and vulnerable citizens in our communities.

Many of these Programs have developed in innovative ways that were not anticipated when the Guidelines were first drafted. The constantly evolving nature of Community Benefits has resulted in an abundant variety of processes, organizations, and Programs. This variety parallels the diversity of hospitals and hospital systems in our state. It allows each hospital to find its "fit" and develop good Community Benefits Programs across a continuum.

Despite this tremendous progress, weaker Community Benefits Programs still exist. As noted throughout this Status Report, there are substantial differences in the quality of the Programs. With efforts such as the Advisory Task Force and the Community Benefits Conference, the Attorney General's Office hopes to provide the assistance and support that will reduce these disparities.

Even so, there is much to be proud of in the Massachusetts Community Benefits experience. Real people are benefitting from Community Benefits. Real partnerships and collaborations are being built. Community Benefits has helped to create new ways of thinking, new ideas to address health care problems, and new relationships between former adversaries. As hospitals take their Community Benefits Programs to higher levels, one can only imagine how much more will be achieved.

ENDNOTES

[1] These Reports are publicly available for inspection in the Attorney General's Division of Public Charities. In addition, copies of these reports have been distributed by region to the Massachusetts Prevention Centers.

[2] The number of hospitals is lower than for the first Attorney General's Status Report, because of several hospital mergers that occurred during the past two years. Therefore, some of the numbers reported in the following section will be lower than those in the first Status Report, but do not reflect declining participation in the initiative.

[3] Unless otherwise noted, statistics are computed from the more recent FY 1997 Annual Reports.

[4] At least one Massachusetts municipal hospital has instituted compensation packages for senior management that are in part tied to community benefit activities and health status improvement. This approach has also been implemented outside of Massachusetts. See California Office of Statewide Health Planning and Development, Report to the Legislature on Not-for-Profit Hospital Community Benefit Legislation (Senate Bill 697) (hereinafter "California Community Benefits Report"), p.26.

[5] Interestingly, California's Community Benefits law (Senate Bill 697) also specifies that hospitals should conduct needs assessments once every three years; however, the agency which oversees their Community Benefits, the Office of Statewide Health Planning and Development, has noted that a needs assessment every three years might be too frequent. California Community Benefits Report at 49-50.

[6] "Asset mapping" involves identifying and comparing both the needs and the resources of a community, such as community organizations and residents who may contribute to health improvement and neighborhood self-sufficiency. See California Community Benefits Report at 42.

[7] The decline in Community Benefits expenditure totals may have also resulted from the decrease in the number of hospitals as a result of mergers during the past two years.

APPENDIX A

HOSPITAL COMMUNITY BENEFITS CONTACT LIST

Anna Jacques Hospital
Susan Gustafson
Community Benefits Coordinator

Athol Memorial Hospital
Allen Young
Vice President, Public Relations & Marketing

BAYSTATE HEALTH SYSTEMS
(Baystate Medical Center, Franklin Medical Center, Mary Lane Hospital)
Todd Lever
Regulatory Affairs Specialist

BERKSHIRE HEALTH SYSTEMS
(Berkshire Medical Center, Hillcrest Hospital, Fairview Hospital)
Sharon Shepard
Director, Development & Community Relations

Boston Medical Center
Valerie Navy-Daniels
Director, Community Relations

Boston Regional Medical Center
Christine Hawrylak
Director, Public Relations

Brockton Hospital
Monique Aleman-Haikal
Director, Community Benefits

CAPE COD HEALTHCARE
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Mary E. McCarthy
CEO, Hospice Foundation of Cape Cod

CARE GROUP

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Ediss Gandelman
Director, Community Benefits

Deaconess-Glover Hospital
Lonny Townley
Director, Community Development

Deaconess-Nashoba Hospital
Elizabeth Greenspan
Vice President, Planning, Marketing & Public Relations

Deaconess-Waltham Hospital
Ann Ormond, Director
Marketing & Community Relations

Mount Auburn Hospital
Marcia Lazar
Director, Mt. Auburn Center for Community Health

New England Baptist Hospital
Janice Sullivan, Director
Community Relations

CARITAS CHRISTI HEALTH CARE SYSTEM
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Vice President, Public Affairs

Carney Hospital
Joyce Coleman
Director, Community Outreach & Volunteer Services

Holy Family Hospital
Mary Ellen Davis
Assistant to the Administrators

Caritas Norwood/Southwood Hospitals
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Community Relations Coordinator

St. Anne's Hospital
Wendy Bauer
Director of Marketing & Planning

St. Elizabeth's Medical Center
Linda Phelan
Manager of Community Benefits

Children's Hospital
Rachel Fulp
Director, Community Benefits

Cooley Dickinson Hospital
Marilyn Richards
Director of Community Relations

Dana Farber Cancer Institute
Ann Levine
Director of Planning

Emerson Hospital
Leslie Luppold
Senior Vice President for Operations

Faulkner Hospital
Tracy Martel
Director, Community Health & Benefits

Good Samaritan Medical Center
Charlene Pontbriand
Vice President, Marketing and Development

HALLMARK HEALTH
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Tim Lawther
Director, Community Relations

Harrington Memorial Hospital
Mara Yerow
Consultant

Heywood Hospital
Lori Martiska
Vice President, Community Relations & Development

Holyoke Hospital
David Wilbur
Director of Planning

Hubbard Regional Hospital
Cynthia Stearns
Director of Public Relations

Jordan Hospital
Christina Nordstrom
Director, Community Education

Lahey Hitchcock Clinic
Kate Hartig
Director, Volunteer & Community Services

Lawrence General Hospital
Barbara Keller
Public Relations Coordinator

Lowell General Hospital
Lisa Breen
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Martha's Vineyard Hospital
Deborah Jernegan
Project Manager

Mass Eye and Ear Infirmary
Mary Leach
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Metrowest Medical Center
Beth Donnelly
Director, Community Benefits

Milford-Whitinsville Reg. Hospital
Jennifer Ansart
Community Benefit Coordinator

Milton Hospital
Susan Lee Schepici
Director of Public Relations & Development

Morton Hospital & Medical Center
Dori Bingham
Director of Public Affairs

Nantucket Cottage Hospital
Michael Sullivan
Director, Community Relations & Development

New England Medical Center Hospital
Howard Spivak
Vice President, Community Programs

Newton-Wellesley Hospital
Ronald Ponte
Director, Patient Relations & Community Partnerships

Noble Hospital
Marjorie Flaherty
Vice President/Nursing Services
Heidi Tracy
Community Benefits Coordinator

North Adams Regional Hospital
Heather McDermott
Director, Marketing

NORTHEAST HEALTH SYSTEMS
(Addison Gilbert Hospital and Beverly Hospital)
John L. Good, III
Vice President, Community Relations & Development
Frances Hesse Larkin, RN, MS
Coordinator, Community Health

PARTNERS HEALTHCARE SYSTEMS
Matt Fishman
Director of Community Benefits

Brigham & Women's Hospital
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Director, Office of Women, Family and Community Programs
Judy Bigby
Medical Director, Office of Women, Family and Community Programs

Massachusetts General Hospital
Joan Quinlan
Director, Community Benefits Programs

North Shore Medical Center
Lori Long
Vice President of Strategic Relations

Saints Memorial Medical Center
Valerie Tramack
Community Benefits

St. Vincent's Hospital
Paula Green
Director, Public/Community Relations

SISTERS OF PROVIDENCE HEALTH SYSTEMS
(Mercy Hospital and Providence Hospital)
Jean Lambert
Vice President, Mission

SOUTHCOAST HOSPITAL GROUP
(Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital)
Ellen Banach
Vice President and Director of Hospital Systems Integration

South Shore Hospital
Richard Pozniak
Director, Public Affairs

Sturdy Memorial Hospital
Linda MacCracken
Chief Market Planning Officer

UNIVERSITY OF MASSACHUSETTS/MEMORIAL HEALTH CARE SYSTEM
Clinton Hospital
Kathy Fadden
Director of Community Relations

Health Alliance Hospital
Augustus Grace
Vice President, Community Relations

Marlborough Hospital
Joyce Hudson
Director, Community Relations

University of Mass. Memorial Medical Center
Cathy Kahn Recht
Manager, Health Care Policy Research

Winchester Hospital
Kathleen Beyerman
Director, Community Health Institute

Wing Memorial Hospital & Medical Center
Judy Duval
Director, Public Relations

LOCATIONS FOR VIEWING COPIES OF ANNUAL HOSPITAL COMMUNITY BENEFITS REPORTS

I. MASSACHUSETTS PREVENTION CENTERS:

(Note: each Prevention Center has only the Annual Reports of hospitals within its service area)

WESTERN MASSACHUSETTS

Lower Pioneer Valley
Massachusetts Prevention Center
110 Maple Street, Suite 301
Springfield, MA 01104
(413) 732-2009
Ellen Leahy-Pile, Acting Director

Greater Western Massachusetts
Massachusetts Prevention Center
10 Main Street
Florence, MA 01052
(413) 584-3880 or (800) 850-3880
Jeff Harness, Director

NORTHEASTERN MASSACHUSETTS

Merrimack Valley
Massachusetts Prevention Center
101 Amesbury Street
Lawrence, MA 01841
(978) 688-2323 or (800) LIVEWELL
Jim Ryan, Director

West Suburban/North Shore
Massachusetts Prevention Center
27 Congress Street
Salem, MA 01970
(978) 745-8890 or (800) 334-5512
Carol Lee Oliver, Director

CENTRAL MASSACHUSETTS

Metrowest - West
Massachusetts Prevention Center
158 Union Avenue
Framingham, MA 01701
(508) 875-5419
Mike Devlin, Director

Central Massachusetts
Massachusetts Prevention Center
531 Main Street
Worcester, MA 01608
(508) 752-8083 or (800) 752-8083
Vanna Lee, Director

GREATER BOSTON

Greater Boston
Massachusetts Prevention Center
95 Berkeley Street
Boston, MA 02116
(617) 423-4337
Margaret Henderson, Director

Metrowest - East
Massachusetts Prevention Center
552 Massachusetts Avenue, Suite 203
Cambridge, MA 02139
(617) 441-0700
Armando Rodrigues, Director

LOCATIONS FOR VIEWING COPIES OF ANNUAL HOSPITAL COMMUNITY BENEFITS REPORTS

SOUTHEASTERN MASSACHUSETTS

Metro/Southeast Massachusetts
Massachusetts Prevention Center
942 West Chestnut Street
Brockton, MA 02401
(508) 583-2350 or (800) 530-2770
Judith Foley, Director

II. OTHER LOCATIONS:

Office of the Attorney General
Public Charities Division
One Ashburton Place
Boston, MA 02108
(617) 727-2200

Office of the Attorney General
Western Massachusetts Office
436 Dwight Street
Springfield, MA 01103
(413) 784-1240

APPENDIX C

CATEGORIZATION OF COMMUNITY BENEFITS PROGRAMS FOR FISCAL YEARS 1996 AND 1997

The total number of Community Benefits Programs reported by hospitals were 1559 in FY 1996 and 1621 in FY 1997. These Programs were aggregated and divided into the following categories:

Community Education

FY 1996: 26.7%
FY 1997: 25.6%

The most frequently-reported Community Benefits Programs fell within the category of Community Education. These Programs provide information on a range of topics, such as nutrition, smoking cessation, and stress reduction.

Community Development

FY 1996: 14.7%
FY 1997: 14.68%

These programs aim to improve community members' employment opportunities, environment, and housing in order to strengthen the community's ability to sustain itself.

Access to Care

FY 1996: 13.1%
FY 1997: 12.58%

This category includes Programs that facilitate the delivery of health care services to the uninsured or underinsured, such as subsidized primary care, transportation, and health information telephone lines. This category also includes efforts that remove language and cultural barriers to health care, such as interpreter services and bilingual/bicultural outreach programs.

Direct Care

FY 1996: 12.3%
FY 1997: 12.09%

These Programs provide direct services to the community, such as immunizations, pregnancy testing, well baby care, counseling, and mobile health vans.

Violence or Substance Abuse Prevention

FY 1996: 10%
FY 1997: 11.6%

These Programs work to prevent family abuse, community violence, and/or substance abuse. These Programs have been grouped together because of overlap amongst some of them. Substance abuse programs also include counseling and behavior modification therapy to treat current abusers.

Screening

FY 1996: 11.5%
FY 1997: 11.23%

These Programs screen for a variety of health problems, such as cancer, HIV, high blood pressure, and elevated lead levels in children.

Support Groups

FY 1996: 7.9%
FY 1997: 8.76%

The Programs include support groups organized for persons with certain diseases, such as Alzheimer's, breast cancer, diabetes, and HIV/AIDS.

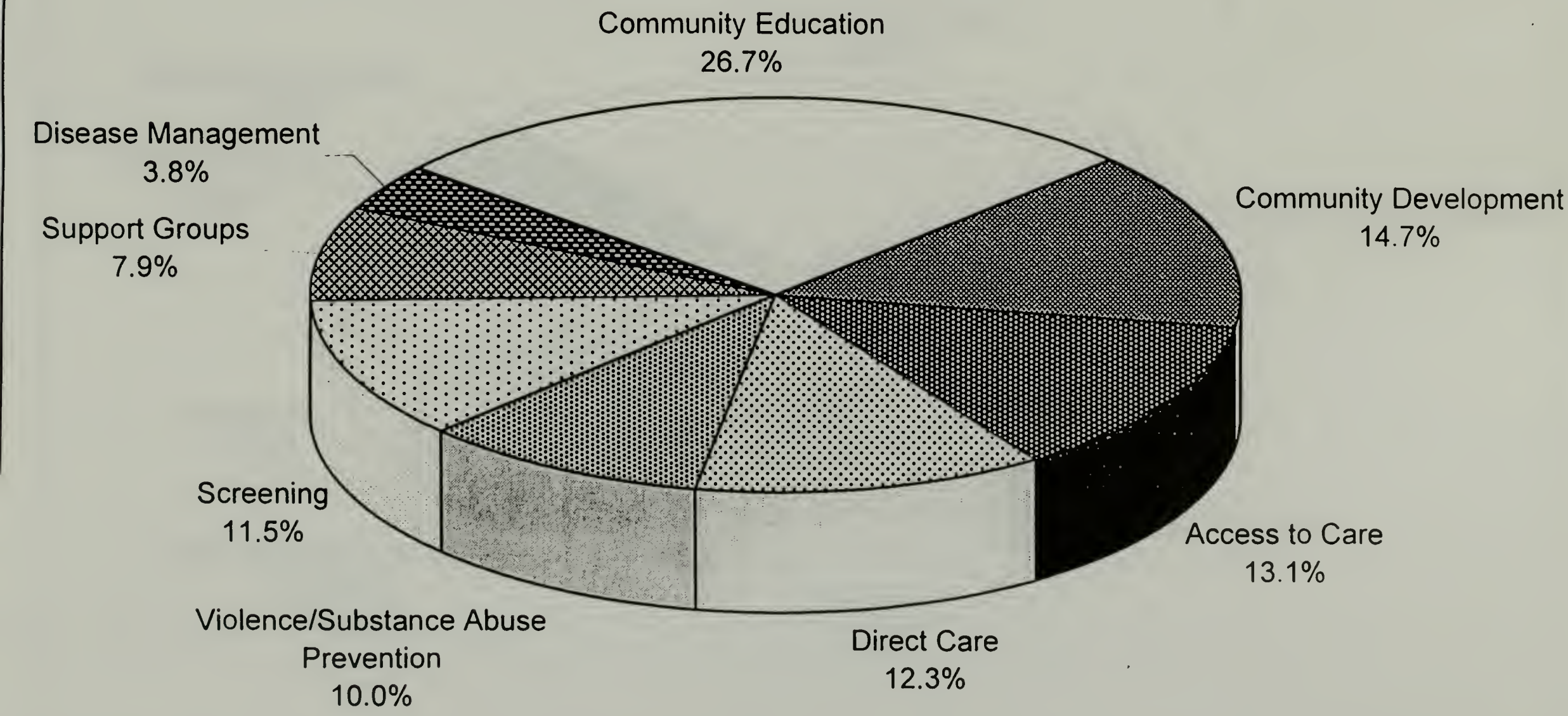
Disease Management

FY 1996: 3.8%
FY 1997: 3.45%

These Programs provide free or low-cost programs to treat, monitor, and follow up with persons who have certain health problems, such as asthma, cardiac or pulmonary disease, obesity, or cancer.

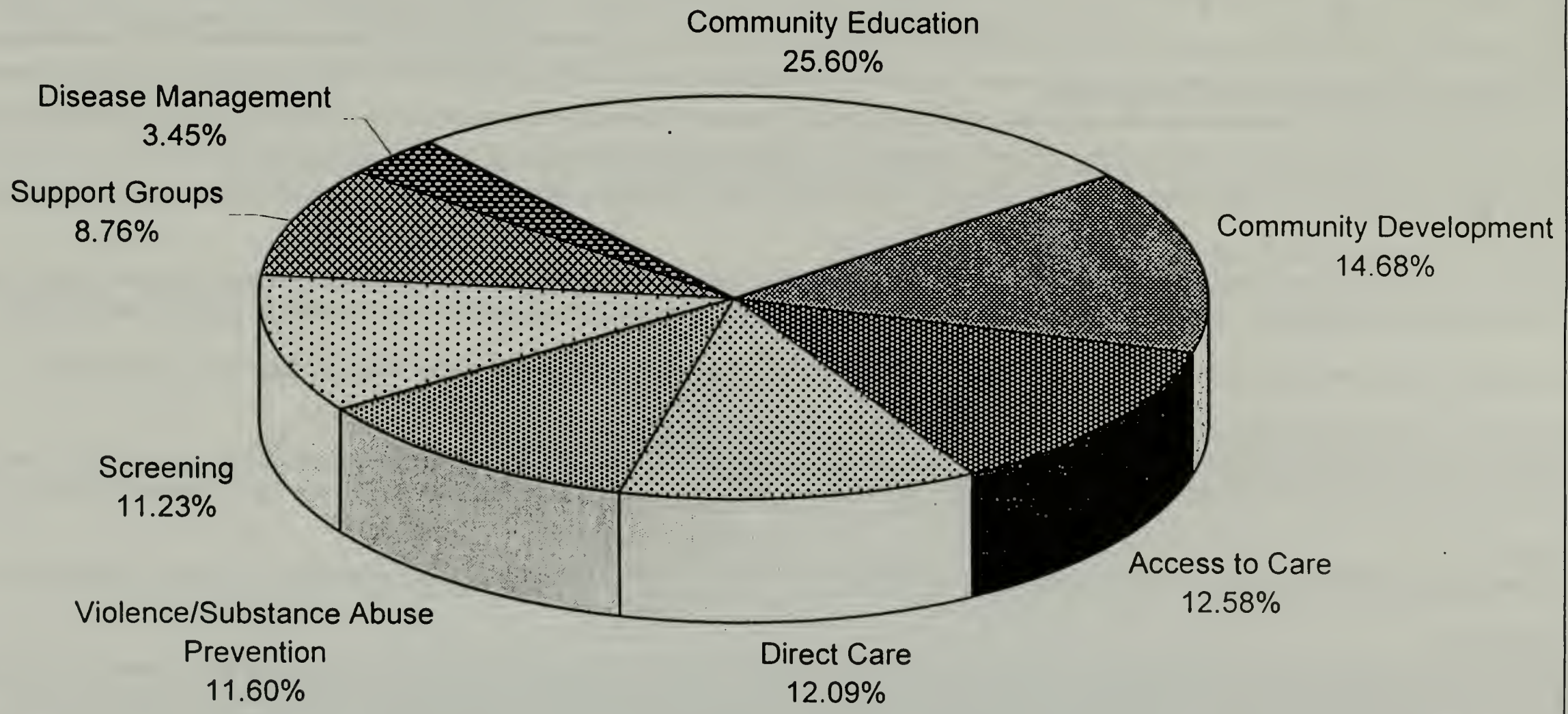
For descriptions of illustrative Programs in each of these categories, please see "Community Benefits 'Best Practices': *A Compendium of Program Summaries Submitted by Massachusetts Hospitals, HMOs and Community Health Advocates.*"

Community Benefits by Hospitals for FY 1996
Program Categories*



*Based upon the aggregated Community Benefits Programs reported in the hospitals' Annual Community Benefits Reports for FY 1996

Community Benefits by Hospitals for FY 1997
Program Categories*



*Based upon the aggregated Community Benefits Programs reported in the hospitals' Annual Community Benefits Reports for FY 1997

APPENDIX D

COMMONWEALTH OF MASSACHUSETTS

Community Benefits Guidelines for Nonprofit Acute Care Hospitals

Financial & Related Information: ***Definitions of Terms***

Community benefits programs are developed through a collaborative process with community representatives as part of a planned response to assessed health care needs.

Gross community benefits means the actual costs to a hospital of providing net charity care and/or broadly defined health care-related community benefits and services in accordance with a hospital's Community Benefits Plan. *Gross community benefits* exclude services paid for or reimbursed by federal and state governments for health care sponsored programs, including Medicaid and Medicare services, and also exclude any "shortfall" in revenue incurred by a hospital for such services.

Net community benefits means *gross community benefits* minus any donations, grants, fees, charges, or other revenue generated as a result of the provision of such services.

Net charity care means the actual costs -- and not the hospital charge -- of providing "free care" to patients, in accordance with the definition of "free care" in M.G.L. Chapter 6B, §1, net of reimbursement by state or federal government or payments from the Massachusetts uncompensated care pool. *Net charity care* may be reported as a community benefit whether or not it is explicitly part of a Community Benefits Plan.

Community service programs are community initiatives and projects that address health care needs but that are not part of a Community Benefits Plan.

Other community contributions: charitable expenditures that generally benefit the community but are not part of the Community Benefits Plan and are not community service programs. Such expenditures might include cash and in-kind donations, payments into the Massachusetts uncompensated care pool, or bad debt resulting from the care of uninsured, indigent patients.

Total patient care-related expenses means the amount that hospitals report as expenses, including capital, relating to the care of patients. We assume that hospitals are reporting here the same amount reported to the Division of Health Care Finance and Policy on Schedule 18 of the 403 Cost Report.

Total patient care-related expenses for reporting year:	

	EXPENDED IN REPORTING YEAR			BUDGETED FOR YEAR FOLLOWING REPORTING YEAR		
COMMUNITY BENEFITS PROGRAM	GROSS COMMUNITY BENEFITS	GRANTS, DONATIONS, OTHER REVENUE	NET EXPENDITURES	GROSS EXPENDITURES	GRANTS, DONATIONS, OTHER REVENUE	NET EXPENDITURES
TOTALS:						

COMMONWEALTH OF MASSACHUSETTS

Community Benefits Guidelines for Nonprofit Acute Care Hospitals

Financial & Related Information

(Optional)

	EXPENDED IN REPORTING YEAR			BUDGETED FOR YEAR FOLLOWING REPORTING YEAR		
COMMUNITY SERVICE PROGRAM	GROSS EXPENDITURES	GRANTS, DONATIONS, OTHER REVENUE	NET EXPENDITURES	GROSS EXPENDITURES	GRANTS, DONATIONS, OTHER REVENUE	NET EXPENDITURES
TOTALS:						

	EXPENDED IN REPORTING YEAR			BUDGETED FOR YEAR FOLLOWING REPORTING YEAR		
OTHER COMMUNITY CONTRIBUTIONS				OTHER COMMUNITY CONTRIBUTIONS		
TOTALS:						